MTR-3
Motion to Reopen by Defendant
May 29, 1997 Edition

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF WORKERS CLAIMS
CLAIM NO. _____
BEFORE _____

_____ PLAINTIFF
(EMPLOYEE)

VS. **MOTION TO REOPEN BY DEFENDANT**

_____ DEFENDANT(S)
(EMPLOYER)

_____
(INSURANCE CARRIER)

_____
(**OTHER DEFENDANTS, IF APPLICABLE)**

_____
(**SPECIAL FUND, IF APPLICABLE)**

****

The undersigned defendant moves to reopen this claim based on the following grounds **(check all that apply)**:

___ Change of disability shown by objective medical evidence
___ Fraud
___ Mistake
___ Newly discovered evidence
___ Medical fee dispute
___ Conforming the award to employee's work status for injuries after 12-12-96.
___ Reducing a permanent total disability award when employee returns to work.

Explanation:

_____

_____

_____

_____

The undersigned further states that the following information is correct **(check appropriate response)**:

1. __ No previous motion to reopen has been filed.

   __ Previous motion to reopen filed
   Month Day Year

On medical fee disputes:

2. __ Utilization review was done on _____. A copy of the decision is attached.
   (DATE)

   __ Utilization review is not required because

This motion is supported by the following attached documents:

1. Affidavit(s) of _____
   (WITNESS NAMES)

2. Medical report of _____
   (DOCTOR'S NAME)

3. A current medical release Form 106 signed and witnessed.

4. A copy of the Opinion and Award, Settlement, Agreed Order, or Agreed Resolution sought to be reopened.

The undersigned, being duly sworn, states the foregoing statements in this motion and in Form 106 are true and accurate to the best of my knowledge and belief.

This the _____ day of _____ 20____.

_____

(DEFENDANT'S SIGNATURE)

Subscribed and sworn to before me this _____ day of _____ 20____.

_____

NOTARY PUBLIC

My Commission expires: _____ County: _____

Respectfully submitted,

_____

(DEFENDANT'S SIGNATURE)

_____

(DEFENDANT'S STREET ADDRESS)

_____

(DEFENDANT'S CITY/STATE/ZIP CODE)

Notice: Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

CERTIFICATE OF SERVICE

I certify that the original was mailed to the Department of Workers Claims, Prevention Park, 657 Chamberlin Avenue, Frankfort, Kentucky 40601 and copies of this motion and attachments were mailed to the names and addresses of the parties given below:

Attorney for Employee if applicable: _____

(Attorney Name or Law Firm)

_____

(**Attorney Address or Law Firm Street Address)**

_____

(Attorney Address, City/State/Zip)

Employee:

_____

(Employee's Name)

_____

(Employee's Street Address)

_____

(Employee's City/State/Zip)

Other Parties, if applicable:

_____

(Name of Party)

_____

(Party Street Address)

_____

(Party City/State/Zip)

Special Fund, if applicable:

_____

(Special Fund)

_____

(Special Fund Street Address)

_____

(Special Fund City/State/Zip)

This _____ day of _____, 20____.

_____

(Defendant's Signature)